



Application for Individual Insurance

907-278-2626 • 888-374-8910 • www.odsalaska.com

Please mail this application to: ODS • Attn: Individual Underwriting • 601 W. Fifth Avenue • Suite 510 • Anchorage, AK 99501

Thank you for choosing ODS Alaska. Please complete all sections of this application. If the application is incomplete or additional information is required, your effective date may be delayed. Illegible and incomplete applications will be returned. We must receive your complete submission including premium 10 days prior to the requested effective date. **You MUST include a premium check or bank draft information from a PERSONAL checking account with this completed application for your application to be processed as complete.**

Notice to applicant: You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information. While you are not required to disclose medical information, including height and weight information, about applicants younger than 19 years of age, you must disclose non-medical information about these applicants, including name, date of birth, sex, and social security number.

Section 1: Type of Application

Requested effective date: 1st: _____ 15th: _____ First available: _____

Your effective date must be within 60 days from the date the application was signed or a new application will be required.

A. New enrollment B. Addition of a dependent to an existing policy C. Upgrade in coverage

New spouse/date of marriage: _____

Newborn/date of birth: _____

Adopted a child/date of placement in my custody: _____

Other: _____

Section 2: Choose a Plan

PREFERRED PPO <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500	BENEFICIAL <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500	BENEFICIAL CHOICE <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500	HSA INDIVIDUAL <input type="checkbox"/> \$1,200 <input type="checkbox"/> \$2,800 <input type="checkbox"/> \$5,000	HSA FAMILY <input type="checkbox"/> \$2,400 <input type="checkbox"/> \$5,600 <input type="checkbox"/> \$10,000
DELTA DENTAL PREMIER PLAN	<input type="checkbox"/> YES, enroll me in the Delta Dental Premier Plan. I have read the dental plan benefit summary and rate sheet and understand the coverage available to me. I understand if I lose eligibility in an individual options medical plan, I will not be able to continue my dental benefits. <input type="checkbox"/> NO, I do not want the Delta Dental Premier Plan. I understand that by declining the dental coverage available to me, the "one-time only" enrollment period will expire and I will not be allowed to enroll in the dental plan at a later date.			

ODS may change or amend the policy or premiums, upon approval by the Alaska Division of Insurance, by giving a 30-day notice before the change is effective. You must reside in the state of Alaska in order to be eligible for coverage. In order to be eligible to enroll in the Delta Dental Premier individual dental plan, you must enroll in an ODS Alaska individual medical plan. The only time you can enroll in a Delta Dental Premier individual dental plan is when you first enroll in an ODS Alaska individual medical plan.

Section 3: Choose a network

<input type="checkbox"/> ODS ALASKA SELECT NETWORK	<input type="checkbox"/> ODS+PROVIDENCE ALASKA NETWORK
Alaska Regional Hospital will be considered my in-network hospital in Anchorage only. All other licensed providers in Alaska will be considered in-network.	Providence Hospital will be considered my in-network hospital in Anchorage only. All other licensed providers in Alaska will be considered in-network.

Section 4: Applicant Information

Applicant Social Security No.		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Applicant Height		Applicant Weight		Home Telephone No.	
Applicant Last Name		First Name		Middle		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth	
Age		Primary Language Spoken		Residence Address		Street		City	
State		ZIP Code (+4)		Mailing Address <i>(if different from residence address)</i>		Street/P.O. Box		City	
State		ZIP Code (+4)		E-mail Address (Subscriber)		E-mail Address (Spouse)			

Section 4: Applicant Information *(continued)*

LIST ALL FAMILY MEMBERS TO BE COVERED.

Last Name of Family Member	First Name	Height	Weight	Gender	Age	Date of Birth	Social Security No.	Primary Language Spoken
Spouse								
Child								
Child								
Child								

Explain relationship to the applicant for any member listed above whose last name is different from the applicant:

DRIVING HISTORY:

In the last 10 years has anyone 19 years of age or older listed on this application been convicted of driving under the influence of any alcohol or drug? Yes No

Explain:

Section 5: Insurance History

Has any insurance company refused or restricted any insurance coverage for you or anyone 19 years of age or older who is listed on this application? Yes No

If yes, name the insurance company and the person affected. Please indicate the reason for declination by the insurance company and the date the declination occurred: _____

Do you or any family members on this application have other active health or medical coverage, Medicare, Medicare Advantage or Medicare supplement coverage? Yes No

If yes, name of insurance company: _____

Effective date of current medical coverage: _____ Termination date of current medical coverage: _____

Have you had prior coverage with ODS in the past five years? Yes No

If yes, please indicate ID #, Group # and name of policyholder insured: _____

Do you or any family members work for an employer who offers health benefits to employees? Yes No

Are you or any family members enrolled? Yes No

If no, why? _____

If you have had prior health coverage and you are applying within 90 days of prior coverage termination you may be eligible for credit towards any pre-existing condition limitation applicable under our plan.

Section 6: Prior Coverage Credit

Prior coverage information: *You must attach a copy of prior plan ID card or certificate of creditable coverage in order to receive prior coverage credit.

**This is not required for applicants under the age of 19.*

Insurance Company	Policy No./Identification No.
Employer Name	Effective Date of Coverage
List any coverage before this <i>(if above coverage was in force less than six months)</i> .	

Section 7: Health History Statement

Please mark "YES" or "NO" for each item (for you and any family members 19 years of age or older requesting coverage). Provide details in Section 7 to any questions answered "YES." **Please include all health history whether or not that condition or the treatment will be covered under this plan.** Has anyone 19 years of age or older listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions within the last 10 years (unless otherwise noted)? The following listed conditions are not inclusive of all medical conditions, your specific condition may not be listed. For the purpose of these questions, "chronic" means persistent, continuous, or periodic, or a combination of these terms.

Please Check Each Item Either Yes or No	Yes	No
ALCOHOL OR DRUG ABUSE		
1. Alcohol/Chemical/Drug Abuse/Habit		
BLOOD DISORDERS		
2. Anemia/Chronic Fatigue/Coagulation Disorders/Hemophilia		
CIRCULATORY		
3. Stroke/Paralysis/TIA/Aneurysm		
4. High Cholesterol (if yes, record last reading in details section)		
5. High Blood Pressure (if yes, record last 3 readings in details section)		
6. Phlebitis/Blood Clot/Peripheral Vascular Disease/Edema		
CONGENITAL CONDITIONS		
7. Birth Defect/Congenital Deformities/Disorders		
EAR, NOSE, THROAT		
8. Chronic Ear/Nose/Throat/Tonsil/Condition or Disorder		
EYE INJURY/DISORDER		
9. Disease or Injury of Eye/Cataract/Glaucoma		
GASTROINTESTINAL CONDITIONS		
10. Appendicitis/Chronic Abdominal Pain/Ulcer		
11. Hiatal Hernia/GERD/Acid Reflux		
12. Hernia (Inguinal, Umbilical, Femoral, Scrotal)		
13. Gallbladder/Pancreatic Disease		
14. Colitis/Diverticulitis/Hemorrhoids/IBS/Blood in Stool		
ENDOCRINE DISORDERS		
15. Diabetes/Sugar in Urine		
16. Goiter/Thyroid-Hyper/Hypo		
17. Adrenal/Pituitary Condition		
HEART CONDITIONS		
18. Heart/Chest pain/Angina		
IMMUNE DISORDERS		
19. AIDS, Aids Related Complex, HIV positive		
KIDNEY/BLADDER CONDITIONS		
20. Bladder or Urinary Tract Infections/Incontinence		
21. Kidney Infections/Stones		
22. Or Other Kidney/Bladder Conditions		
LIVER CONDITIONS		
23. Hepatitis/Cirrhosis		

Please Check Each Item Either Yes or No	Yes	No
MUSCULOSKELETAL CONDITIONS		
24. Back or Neck Pain/Strain/Disc problems		
25. Spinal Adjustments/Chiropractic Care (#____past year)		
26. Fractures (specify if hardware is present)/Bone spur		
27. Carpal Tunnel Syndrome/Tendonitis/Bursitis/Gout		
28. Joint Disorder/Replacement/Dislocation/Rheumatoid Arthritis/Osteoarthritis		
29. Lupus/Muscle Injury or Disease/Fibromyalgia/TMJ		
30. Osteoporosis/Osteopenia		
MENTAL HEALTH DISORDERS		
31. Anxiety/Depression/Bipolar/Attempted Suicide/Other Mental Health		
32. Therapy/counseling (if yes, record last session date in details section)		
NEUROLOGICAL CONDITIONS		
33. Brain Disease or Injury/Concussion		
34. Chronic Headaches/Migraines		
35. Multiple Sclerosis/Paralysis/Cerebral Palsy		
36. Neurodevelopmental/Cognitive/Motor/Speech Delay		
37. Seizures: Grand Mal/Petit Mal/Convulsion/Epilepsy/Other		
ORGAN (PROVIDE 15 YEARS OF HISTORY)		
38. Transplant		
39. Organ Cyst/Tumor		
40. Cancer (specify type, location extent:_____)		
41. Or Other Organ Disorders		
REPRODUCTIVE SYSTEM CONDITIONS/SEXUALLY TRANSMITTED DISEASES		
42. Reproductive System Disorder/Infertility		
43. Prostate/elevated PSA/Prostatitis		
44. Genital Herpes/Human Pap. Virus (HPV)/Genital Warts		
RESPIRATORY CONDITIONS		
45. Allergies/Emphysema/Asthma/Chronic Lung Disease (COPD)		
46. Sleep Apnea/Chronic Sleep Disorder/TB/Cystic Fibrosis		
SKIN CONDITIONS		
47. Acne/Eczema/Psoriasis		
48. Cancer/Abnormal Moles		

Section 7: Health History Statement (continued)

49. Weight fluctuation (+/-20 lbs)? Yes No
50. Cosmetic surgery/implants or use of prosthetic devices/limbs? Yes No
51. I (have have not) used any tobacco products during the 12 months immediately preceding the date of this application. (Not checking a box will result in paying the smoker rate.)
52. My spouse and/or dependent children 19 years of age or older (if included on this application) (has has not) used any tobacco products during the 12 months immediately preceding the date of this application.
53. Is any person 19 years of age or older listed on this application now pregnant or in the process of adopting a child? Yes No
If yes, name: _____ Due date: ____/____/____
54. Is any person 19 years of age or older on this application, including male applicants and dependent males or females, responsible for a current pregnancy? Yes No If yes, name: _____ Due date: ____/____/____
55. Please provide the following information for each person on this application. You **must** provide details in Section 7 to any questions you answer with “yes” between questions 55a and 55d.
Within the past 10 years, has any person 19 years of age or older listed on this application:
- a. Had any medical advice, diagnosis, care or treatment — including prescribed medications — recommended or received from a licensed healthcare professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above? Yes No
 - b. Had chronic cough, fatigue, diarrhea or enlarged glands? Yes No
 - c. Been advised to have or contemplated having an operation or medical procedure not yet performed? Yes No
 - d. Been scheduled to see a healthcare provider or scheduled future appointments? Yes No
56. List all medications currently being taken by any person 19 years of age or older listed on this application (please attach an additional sheet if necessary):

Name	Medication (Name, dose, duration)	Prescriber	Date Prescribed

57. Please provide the following information for each **female** 19 years of age or older listed on this application:

Family member	Name:	Name:	Name:	Name:
a. Date of last menstrual period				
b. If (a) is more than 35 days ago, please explain				
c. Excessive or absent menstrual bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Abnormal Pap smears?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Prior cesarean section or miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 8: Health Statement

Please provide specific details below to each question answered yes on pages 3-4. Include applicant's name, the number of the question to which you answered "yes"; the condition, treatment and date; the result of treatment, including any medications; and the name, address and telephone number of the attending physician, or other healthcare provider, or clinic/hospital.

Name	Question Number	Start to End Dates	Condition (specific illness or injury)	Treatment (including medications)	Final Result, Ongoing or Resolved (circle one)	Attending Physician/ Healthcare Provider/Hospital
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	
					O/R	

You must list a name, address and telephone number of a medical provider with current medical records/history for each family member to be covered. (This may be the last provider seen for an annual physical.)

	Name	Primary Provider's Name	City/State	Phone No.	Date Last Seen
Primary Applicant					
Spouse					
Child					
Child					
Child					

Section 9: Waivers and Downgrades

Would you accept waivers on pre-existing conditions? Yes No

(Waiver: Waiving (excluding) from coverage for one or more pre-existing conditions identified by the insurance carrier.)

Would you accept a downgrade? Yes No

(Downgrade: Insurance carrier may limit the individual health benefit plans in which the individual may elect to enroll because of one or more pre-existing conditions.)

If you receive a waiver or downgrade offer, you must sign the amendment to put the policy into force indicating your acceptance based on the terms stipulated by the offer.

Section 10: Agent of Record

I (the agent) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by ODS. In order for you to become the Agent of Record, you must sign and date below.

I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Agent name: _____

Agency name: _____ Phone No.: _____

Street address: _____ City: _____ State: _____ ZIP: _____

I affirm all health information provided to me has been accurately reflected on this application I disclose to ODS.

Agent's signature (required): _____ **Date:** _____

NOTE TO AGENT: COLLECT PREMIUM WITH APPLICATION.

Section 11: Authorization

Be sure to sign and date the application below. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Conditional Authorization to Use/Disclose Protected Health Information":

CERTIFICATION OF COMPLETION AND CORRECTNESS: I affirm that the answers given in this application for individual coverage are complete and correct to the best of my knowledge. I have provided these answers as part of the application procedure required by ODS to enroll in its insurance coverage. I understand that if this application contains any fraudulent or intentional material misrepresentation, ODS may, deny coverage, modify or cancel the policy, or take other legal action. I further understand that if the misrepresentation amounts to fraud, ODS may deny coverage, modify or cancel the policy, or take other legal action even after the first three years of coverage. I will promptly inform ODS in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by ODS. If approved, coverage will be in force as of the effective date determined by ODS. ODS may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

CONDITIONAL AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION:

Applicant: _____ Applicant: _____

Applicant: _____ Applicant: _____

I (We) authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or any other third-party source including, but not limited to Medical Information Bureau (MIB) financial institution, Division of Motor Vehicles and Pharmacy vendors, to use and disclose a copy of my protected health information to ODS Health Plan, Inc. for the purpose of enrollment determination or eligibility, claim payments and policy underwriting.

My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness and any other personal or medical information related to the purpose of this authorization. Information obtained with this authorization will be used for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization. Any uses or disclosures already made with my permission cannot be taken back. Unless revoked, this Authorization shall be in force and effect for twenty-four (24) months from the date of the signature below.

To revoke this Authorization, please send a written statement to ODS Health Plan, Inc., Privacy Office, 601 S.W. Second Avenue, Portland, OR 97204 and state that you are revoking this Authorization. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization we may decline to enroll you in our health plan, provide benefits and payment for treatment.

I (We) have reviewed and I (we) understand this Authorization.

By: _____ Date: _____
Signature of Applicant

By: _____ Date: _____
Signature of Spouse (if applying for coverage)

By: _____ Date: _____
Signature of Child Age 18 or Over (if applying for coverage)

By: _____ Date: _____
Individual's Representative

Relationship to member: Parent Legal guardian* Holder of Power of Attorney*

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.

Section 12: Billing Information

Please indicate your billing choice.* If you request Auto Pay or draft of the initial premium, please complete the Auto Pay Authorization Agreement and attach a voided check from the account to be drafted.

AUTO PAY (EFT)

Save time and paper by having funds transfer automatically around the fifth calendar day of each month. Please attach a photocopy of a voided check from the personal account to be drafted. The initial premium will be deducted via Auto Pay. If you prefer, you may attach a personal check for your first month's premium.

MONTHLY BILLING STATEMENT

A \$5.00 monthly administration fee is required with this payment method. Please attach a personal check for one month's premium. You will receive a bill every month.

Please indicate here if you would like ODS Alaska to draft the initial monthly premium and begin monthly billing statements for subsequent billings.

QUARTERLY BILLING (EVERY THREE MONTHS)

A \$5.00 quarterly administration fee is required with this payment method. Please attach a personal check for three months' premium. You will receive a bill every three months.

Please indicate here if you would like ODS Alaska to draft the initial quarterly premium and begin quarterly billing statements for subsequent billings.

**If no billing option is selected, then you are agreeing, by default, to a monthly billing statement with a \$5.00 monthly administration fee.*

BILLING WORKSHEET

Billing Option

MONTHLY

QUARTERLY

Medical plan monthly premium

\$ _____

\$ _____

Dental plan monthly premium

+ \$ _____

\$ _____

Total due to ODS Alaska

= \$ _____

\$ _____

(If monthly EFT was chosen, please attach a voided check and fill out the section below.)

(Multiply times three; do not fill out section below.)

AUTO PAY AUTHORIZATION AGREEMENT

Instructions:

1. Complete and sign below as account holder for monthly automatic bank deduction of insurance premium.
2. Attach a photocopy of your "voided" personal check from the account to be drafted. (Contact ODS Alaska if you prefer to use a savings account instead of checking.)
3. Submit the completed application and appropriate documents with your application.

Applicant: _____ Account holder: _____

I (or we, if this is a joint account) authorize ODS Alaska to charge my (our) checking account for monthly insurance premiums for the above named individual. I also authorize my bank named here to honor these monthly charges. This authority will remain in effect until I give my bank a reasonable chance to act upon it. I can stop payment by notifying my bank before my account has been charged.

Name of bank: _____

Signature of account holder: _____ Date: _____

You may be billed for the premium payment necessary to begin electronic deductions. If you wish to cancel your bank deductions, we must receive written notice 15 days before the next deduction date.

Please make checks payable to ODS Alaska.

***Individual benefit plans are not intended for sale as an employer-sponsored health benefit for employees. For this reason, an individual policy cannot be paid with a business check and must be drawn on personal accounts not affiliated with a business. For information on small employer health benefit plans, contact the ODS Alaska Marketing Department at 907-278-2626 or 888-374-8910.**

NOTE: Sending in a check does not guarantee coverage. The first month or quarterly premium amount will not be credited to your account until your application for individual health insurance coverage has been approved by ODS Alaska Underwriting. You will be notified in writing of your application status no later than 60 days from receipt. If your application is approved, the coverage effective date will be the first or 15th day of the month following approval. If your application is not approved, you will be notified in writing and your check will be returned to you. ODS Alaska may change or amend the policy or premiums, upon approval by the Alaska Division of Insurance, by giving a 30-day notice before the change is effective.

